



COLOMBO PLAN



AFGHANISTAN  
NATIONAL DRUG USE SURVEY  
**EXECUTIVE SUMMARY**  
**MAY 2015**









# ACKNOWLEDGEMENTS

This document was prepared by SGI Global, LLC under contract with The Colombo Plan and with special guidance from the, Bureau for International Narcotics and Law Enforcement Affairs, U.S. Department of State.

## **Prime Contractor and Program Manager**

Harold D. Wankel  
SGI Global, LLC

## **Project Manager**

Donald K. Rothenbaum  
NES, Inc.

## **Afghanistan Medical Team Director**

Dr. Mohammad Asrar Ghani  
SGI Global, LLC

## **Science Team Director**

David M. Martin, PhD  
JMJ Technologies, Inc.

## **Distinguished Professor and Chief Scientist**

Dr. Mark S. Gold  
Director of Research  
Drug Enforcement Administration  
Educational Foundation

## **Toxicology Consultant and Special Advisor**

Bruce A. Goldberger, PhD  
University of Florida

## **Drug Testing Coordinator and Special Advisor**

Joseph Jones, MS, NRCC-TC  
United States Drug Testing  
Laboratories, Inc.

## **INL, U.S. Department of State Program Advisors**

Thomas Browne  
Chief, Criminal Justice Division  
Brian Morales  
Foreign Affairs Officer

## **Statistical Analysis Team**

Pallavi Chitturi, PhD  
Lauren Nicole Spirko, PhD  
Center for Statistical Analysis  
Temple University, Philadelphia

## **Senior Report Editor and Publisher**

Julie Weber-Roark

## **Report Review and Edit Team**

Esther Lofgren, SGI Global, LLC  
William Sohn, SGI Global, LLC  
Kyle Rothenbaum, NES, Inc.  
Bu Hyoung Lee, Temple University

This survey would have been impossible without the dedication and bravery of SGI Global's Afghanistan Medical Team. Team members collected over 30,000 samples from over 10,000 individuals during a period of six years and often under extreme and dangerous circumstances. Special thanks and appreciation go to:

Dr. Mohammad Asrar Ghani

Dr. Abdul Shukoor Haidary

Dr. Eram Malekzai

Dr. Shareefullah Shareefi

Dr. Sayed Jawad Fekrat

Dr. Fakhera Fekrat

Dr. Gulalai Haidari

Dr. Rahila Nadir

Dr. Torpekai Ghani

Nooria Rahimi

Firozan Hussaini

This historic work would not have been possible without their outstanding contributions.

The science team extends its appreciation to the Bureau of International Narcotics and Law Enforcement Affairs, U.S. Department of State. Their vision, assistance and guidance made the survey possible. INL's sincere caring for Afghanistan and especially its children was critical to the survey's implementation and success.

The science team also extends its appreciation to The Colombo Plan Drug Advisory Programme. Their vast experience of conducting projects in Afghanistan as well as knowledge and expertise of problems related to drug use in Afghanistan was a key factor in the implementation and success of this survey as well.

The science team wishes to especially thank and acknowledge the efforts and assistance of the following individuals from the Government of the Islamic Republic of Afghanistan:

**Dr. Suraya Dalil**

*Former Minister of Public Health*

**Zarar Ahmad Osmani**

*Former Minister of Counter Narcotics*

**Dr. Mohammed Nabi Hussaini**

*Former Director, Ministry of Counter Narcotics*

**Dr. Bashir Noormal**

*Ministry of Public Health, Afghanistan Public Health Institute (APHI)*

**Dr. Abdullah Wardak**

*Former Head of Drug Demand Reduction Department, Ministry of Public Health*

# AFGHANISTAN FACT SHEET

## Population Estimates

Population <sup>1</sup>	26,023,100–31,822,800
Urban Population	6,275,600–7,674,200
Rural Population	19,747,500–24,148,600
Adult Population (57.7% of Population) <sup>2</sup>	15,015,329–18,361,756
Urban Adult Population	3,621,021–4,428,013
Rural Adult Population	11,394,308–13,933,742
Adult Male Population (51.2% of Adults) <sup>2</sup>	7,687,848–9,401,219
Urban Male Population	1,853,963–2,267,143
Rural Male Population	5,833,885–7,134,076
Adult Female Population (48.8% of Adults) <sup>2</sup>	7,327,480–8,960,537
Urban Female Population	1,767,058–2,160,871
Rural Female Population	5,560,422–6,799,666
Child Population (42.3% of Population) <sup>3</sup>	11,007,771–13,461,044
Urban Child Population	2,654,579–3,246,187
Rural Child Population	8,353,193–10,214,858
Ethnic Groups <sup>4</sup>	
Pashtun	42%
Tajik	27%
Hazara	9%
Uzbek	9%
Aimak	4%
Turkmen	3%
Baloch	2%
Others	4%
Languages <sup>4</sup>	
Persian or Dari	50%
Pashto	35%
Turkic	11%
Minor languages	4%
Religions <sup>4</sup>	
Sunni Muslim	80%
Shia Muslim	19%
Other	1%

<sup>1</sup> The two population estimates are derived from the Afghanistan Central Statistics Organization (lower estimate) and CIA World Factbook (upper estimate) for 2013–2014.

<sup>2</sup> CIA World Factbook estimate of child and adult population percentages.

<sup>3</sup> Children are classified as individuals aged 0–14 years.

<sup>4</sup> <https://www.cia.gov/library/publications/the-world-factbook/geos/af.html>.

# EXECUTIVE SUMMARY

## AFGHANISTAN NATIONAL DRUG SURVEY 2015

### BACKGROUND

The Afghanistan National Drug Use Survey (ANDUS) was conducted by the United States Department of State, Bureau of International Narcotics and Law Enforcement Affairs (INL), with oversight by the Institutional Review Board of the Islamic Republic of Afghanistan's Ministry of Public Health. ANDUS is unique from earlier drug-use surveys in Afghanistan as it is the first large-scale national survey to use objective laboratory hair, saliva, and urine drug testing. The goal of the survey was to produce an objective assessment of drug use in the country of Afghanistan that will guide its government, the United States Department of State, and international communities in developing strategies for illicit drug demand reduction. The results of the survey can also be used to design culturally specific drug-abuse prevention and treatment programs in Afghanistan. The survey was conducted in two phases and covers 24 of Afghanistan's 34 provinces. The first phase surveyed 11 provincial capitals ("urban survey") and the second phase surveyed 52 rural villages in 15 provinces ("rural survey"). Together, the surveys profile the nature and extent of urban, rural, and national drug use in Afghanistan.

### METHODOLOGY

Hair, urine, and saliva were collected from 10,549 Afghans who consented to participate in the survey. These individuals were sampled from 2,757 randomly selected households in 11 urban centers and 52 rural villages. The survey protocols were submitted for Institutional Review Board (IRB) oversight to the Afghanistan Ministry of Health and American Institutional Review Boards. Confidentiality was and is being maintained to protect the identities of all participants.

More than 30,000 hair, urine, and saliva samples were tested for 10 different classes of drugs by an accredited research laboratory in the U.S. The samples were first screened by drug class. If the sample tested positive for a particular class of drug, that sample was analyzed by the appropriate analytical method to confirm the results and to identify the specific drugs and concentrations in the positive sample.

### SURVEY RESULTS

Table 1 presents the national, urban, and rural household and population drug-positive rates. Household rates are based on a positive test from one or more individuals living in the same household. Population rates are based on the percent of individuals testing positive. Total population rates are derived by weighting the percent positives of men, women, and children (those 0–14 years of age) to their respective percentages of the population and combining the weighted percentages. Adult rates, for those 15 years of age and older, combine the weighted rates for men and women. The term "rate" when used alone refers to the mean percentage testing positive.

Table 2 presents the national, urban, and rural drug-use rates. Drug-positive adults are assumed to be drug users, but the same assumption cannot be made for

**Table 1. Survey Results—Drug Positive Rates**

	Urban	Rural	National
Household	11.4%	38.5%	30.6%
Population	5.3%	13.0%	11.1%
Adults	7.5%	14.5%	12.8%
Men	10.6%	17.8%	16.1%
Women	4.3%	11.2%	9.5%
Children	2.3%	11.3%	9.2%

**Table 2. Survey Results—Drug Use Rates**

	Urban	Rural	National
Population	4.4%	8.2%	7.3%
Men	10.6%	17.8%	16.1%
Women	4.3%	11.2%	9.5%
Children	0.2%	1.0%	0.8%

**Table 3. Survey Results—Drug Positive Rates by Drug Class**

	Urban	Rural	National
Any Drug	5.3%	13.0%	11.1%
Opioids	2.6%	8.9%	7.4%
Cannabis	1.7%	3.9%	3.4%
Benzodiazepines	1.0%	0.8%	0.8%
Barbiturates	0.3%	0.2%	0.2%
Alcohol	0.3%	0.1%	0.1%
Amphetamine-Type Stimulants	< 0.1%	0.4%	0.3%
Other Drugs	0.0%	< 0.1%	< 0.1%

children. Most of the children were found to be positive from exposure to drugs smoked by adults in the home or were given the drug, possibly for medicinal or behavior-control purposes. An inclusion and exclusion criteria was established for various opioid compounds detected in the hair, urine, and saliva of children. These criteria indicated no more than 9% of opioid-positive children may be active drug users. Extended to other drugs, 9% of children who tested positive are assumed to be possible drug users.

The national, urban, and rural drug-positive rates by drug class are presented in Table 3. The types of drugs used by rural and urban adult drug users do not differ significantly. The rates for rural and urban Afghan adults differ, and in some cases, the differences are significant. Opioids and cannabis are the drugs used the most throughout Afghanistan.

## KEY FINDINGS:

- Nearly one-third (31%) of all households tested positive for one or more drugs. The rural household rate is more than three times higher: 39% rural compared to 11% urban.
- Over ten percent (11%) of the population tested positive for one or more drugs with the rural population rate almost three times greater: 13% rural versus 5% urban.
- Approximately 13% of adults tested positive for one or more drugs. The rate for rural adults is almost two times higher: 15% rural compared to 8% urban. About 16% of men and 10% of women tested positive. Drug use among rural men is almost two times higher: 18% for rural men compared to 11% for urban men. Drug use among rural women is almost three times higher: 11% of rural women compared to 4% of urban women.
- Approximately 9% of Afghan children tested positive for one or more drugs. The percentage of rural children who tested positive is almost six times higher: 11% rural compared to 2% urban.

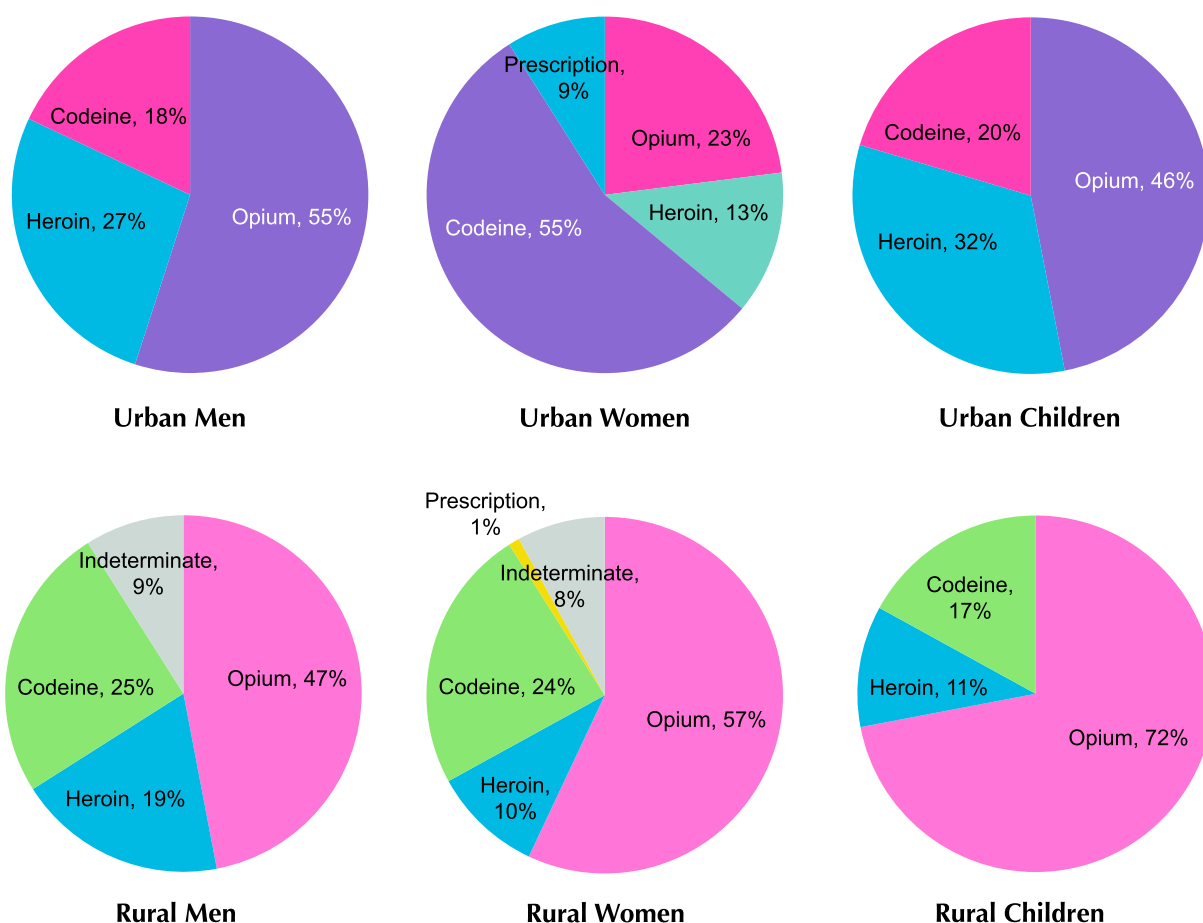
## OPIOIDS

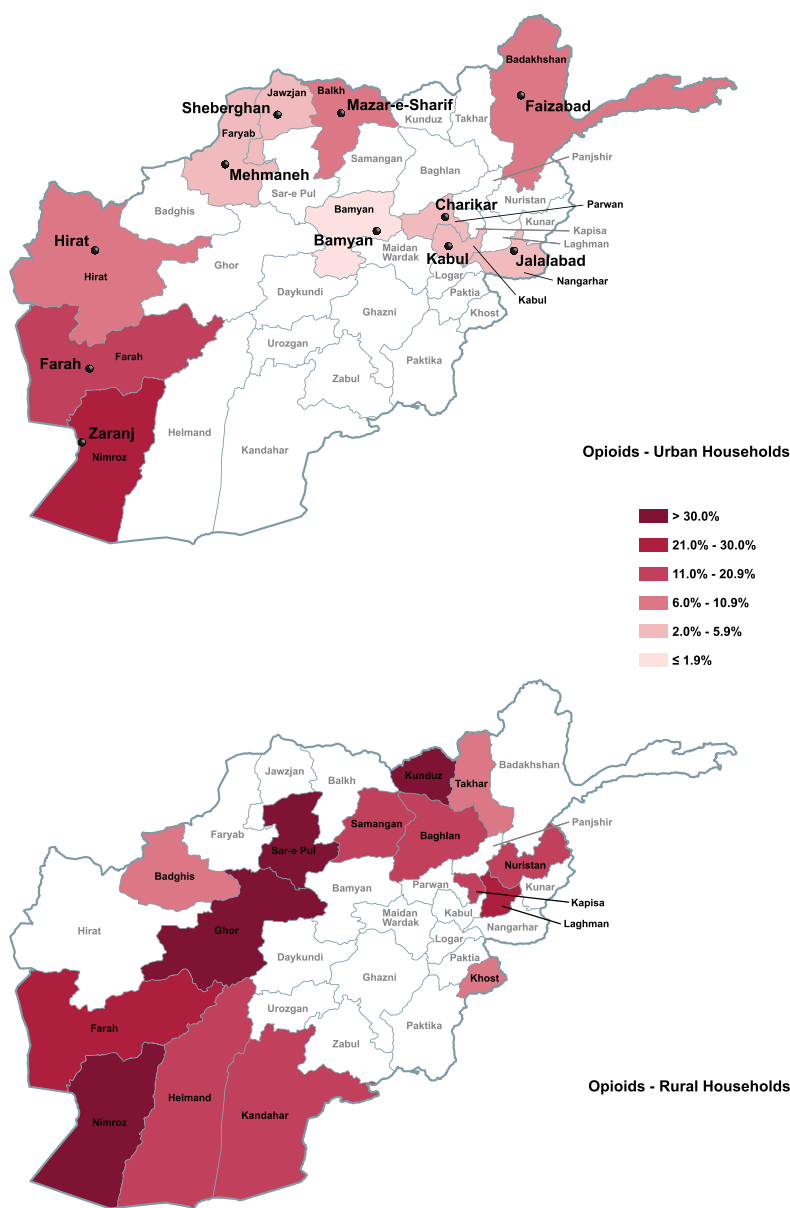
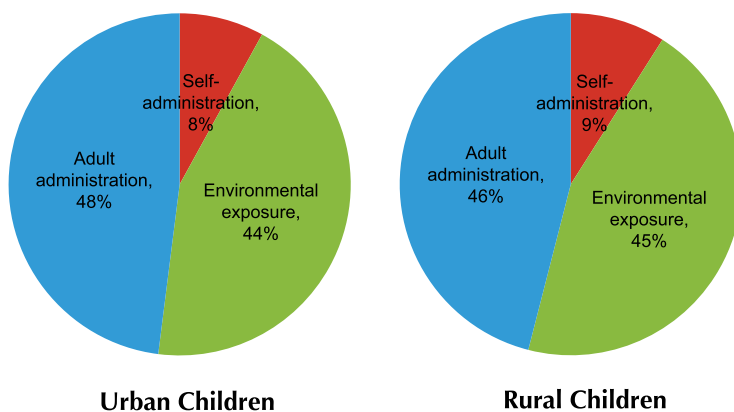
Opioids are the most prevalent class of drugs in Afghanistan. Opioid use is significantly higher in rural villages than in the urban centers (see maps). It is used in nearly one out of five Afghan households (19%). Opioids were detected in one quarter (25%) of all rural households and the rate is more than four times higher than among urban households (6%). Approximately 7% of the population tested positive for opioids with the rural rate approximately three times higher: 9% rural compared to 3% urban. Approximately 6% of children tested positive for opioids. The percentage of rural children who tested positive for opioids is approximately six times higher: 1.3% urban compared to 7.5% rural.

While drug tests alone cannot determine

the origin of opioids or route of administration, the concentration and distribution of opioids in hair, saliva and urine can be used to determine whether opium, heroin, and/or codeine was used. Differences in the types of opioids used by urban and rural adults and the types of opioids detected in children are indicated as shown in the Figure below.

These data show that the types of opioids used by urban and rural male opioid users are generally similar, but most appear to be using opium, an opioid that predominantly contains morphine. A higher percentage of men than women use heroin, a drug manufactured from morphine. Urban women predominantly use an opioid that contains more codeine than morphine. Urban women use heroin, a drug manufactured from morphine. Urban women predominantly use an opioid that contains more codeine than morphine. Approximately the same percentages of rural men and women appear to be using an opioid predomi-





nantly containing codeine.

Most of the children tested positive, either from use of exposure. A higher percentage of urban children than rural children tested positive for heroin. A similar percentage of urban and rural children tested positive for an opioid predominantly containing codeine.

The origin or form of the opioid that predominantly contains codeine is not known. Some possible sources could be pharmaceuticals containing codeine, byproducts of heroin manufacturing being sold as a low-grade form of opium, or other non-pharmaceutical-grade codeine medications. Further study and information would be needed to identify its origin.

The Figure above displays the percentage of children who tested positive from three sources: environmental exposure, adult administration, and self-administration (intentional use). The majority (> 90%) of urban and rural children tested positive from environmental exposure or from being given the drug by adults, most likely for analgesic and/or calming purposes. About 9% of children who tested positive met the criteria to be considered active users. In general, the classification used age and the concentration and distribution of opioids in hair, urine, or saliva. Children were identified as a user if they were eight years and older and positive with high levels of opioids in hair or any amount in urine or saliva. Children younger than eight

years old and positive for opioids at high levels in hair or any amount in their urine or saliva were presumed to be positive because they were administered the drug by adults. Children with low levels of opioids only in hair were presumed to be positive due to environmental exposure.

Whether children are users or are being exposed to the drug by adults, the rate and number of children testing positive for opioids is significant. The physiolog-

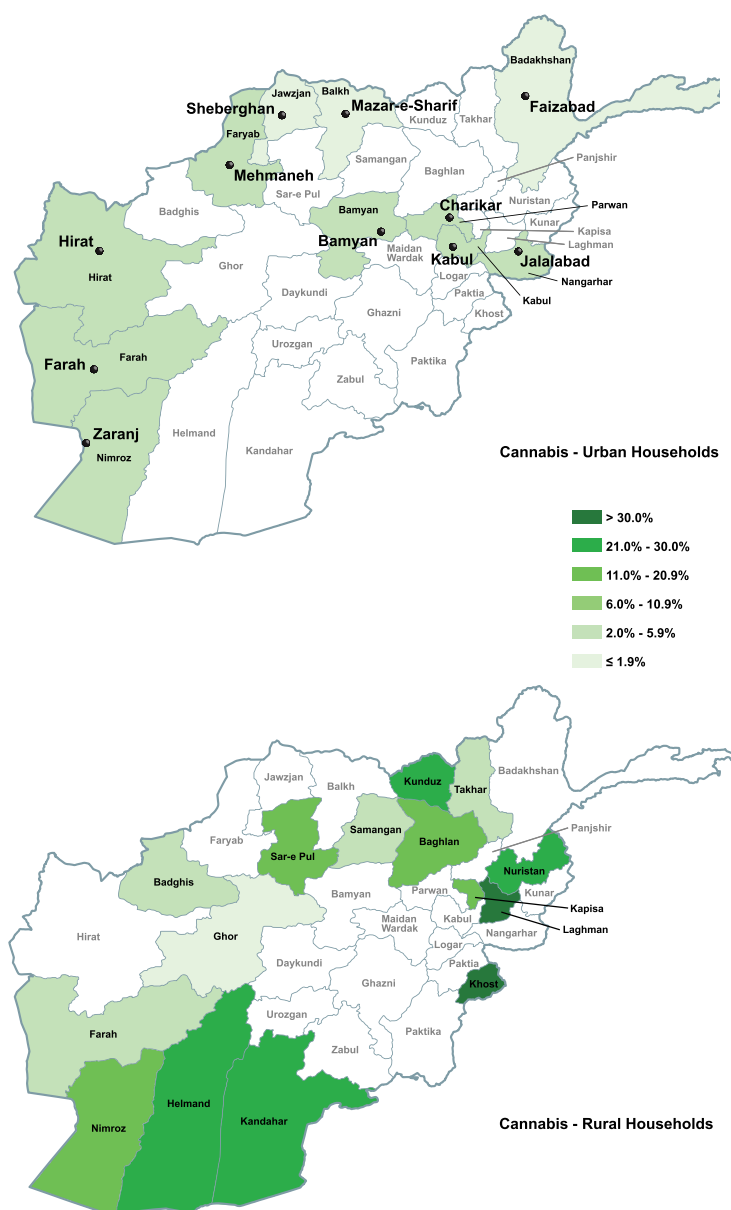
ically based pharmacokinetic (PBPK) model suggests that morphine, an opioid compound, builds up in the brain and other organs, especially in younger children. Early childhood exposure to opioids could lead to significant future health problems including drug abuse.

## CANNABIS

Cannabis is the second-most prevalent drug in Afghanistan but at a rate lower than opioids. It was detected in 11% of households and 3% of the population (see maps). Almost five times more rural households tested positive for cannabis: 14% rural and 3% urban. The population rate is low at approximately 3%, but the rate is higher in rural Afghanistan: 4% rural and 2% urban.

Cannabis is used primarily by men. Cannabis use by women is low: it was detected in less than 1% of urban women and 2% of rural women.

Approximately 3% of children tested positive for cannabis. Six times more rural children tested positive for cannabis compared to urban children: rates were approximately 3.6% rural and 0.6% urban. The majority of the children most likely tested positive from environmental exposure.



## BENZODIAZEPINES

Benzodiazepines are the third-most detected drug type but at rates significantly lower than opioids or cannabis. The national household rate is approximately 5%, and the population rate is 1%. The rural household rate is higher than the urban rate, but the population rates for rural and urban are similar.

## BARBITURATES

Barbiturate use is low. The national rate is approximately 1% of households and less than 1% of the population. The rural and urban rates are not significantly different.

## ALCOHOL

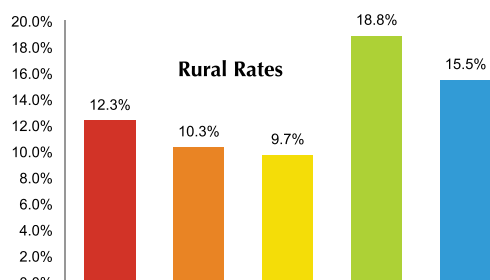
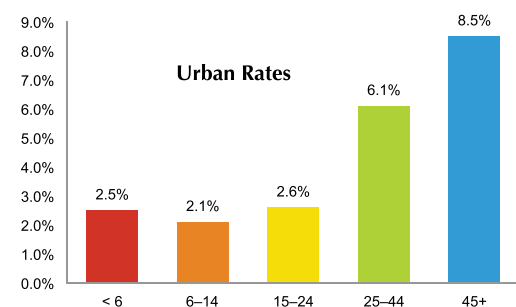
Alcohol use is very low in Afghanistan. It was detected in approximately 1% of households and less than 1% of the population. Though the rates are not significant, alcohol was detected more often among women than men.

## AMPHETAMINE-TYPE STIMULANTS

Amphetamine-type stimulant (ATS) use is low and was detected in approximately 2% of households and less than 1% of the population. Although the rural rate is low, the ATS rural rate is higher at 2% while the urban rate is less than 1%. No urban children tested positive for ATS, but this drug class was detected in children in three rural villages.

## AGE

The Figures below present the urban and rural use rates by the following age



groups: less than 6 years, 6-14 years, 15-24 years, 25-44 years, and 45 years and older.

The highest urban rate is among adults 45 and older, and among the rural population, the highest rate is among adults 25-44 years old. Afghans 15-24 years old have the lowest rate among both urban and rural adults.

Opioids are used mostly by urban and rural men and women 25 years and older. Cannabis is used the most by younger urban men who are 15-24 years old and rural men 25-44 years old. Benzodiazepines are used mostly by older urban men and women, those 45 years and older, and rural women who are 25-44 years old. ATS were detected more often among rural men who are 25-44 years old and among urban men 25 years and older.

## KABUL CITY

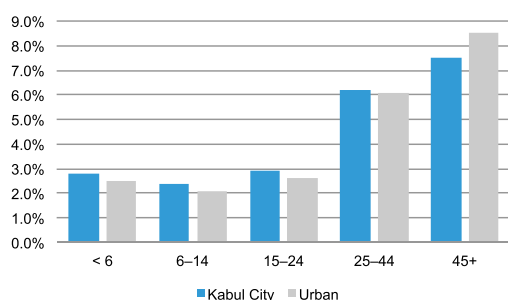
A total of 1,333 households from 16 police districts of Kabul City were sampled, and 3,225 people from those households were tested. The results for Kabul City are presented citywide and by quadrants of the city.

The household and population rates by drug class for Kabul City are presented in Table 4. The urban and national rates are also presented for comparison. As shown by the table, the rates in Kabul are similar to the nationwide urban rates. This is due to Kabul City being the largest urban population center in Afghanistan where more than 50% of the country's total urban population lives.

Approximately 11% of households and 5% of Kabul's population tested positive for any drug use. Among men, approximately 10% tested positive for one or more drugs with a higher percentage testing positive for cannabis than opioids: 5% for cannabis compared to 4% for opioids. Among women, about 4% tested positive for one or more drugs, with opioids being detected the most often at approximately

**Table 4. Survey Results—Kabul Drug Positive Rates**

	Any Drug	Opioids	Cannabis	Benzodiazepines	Barbiturates	Alcohol	Amphetamines
Household	11.1%	5.0%	3.9%	2.4%	0.7%	0.8%	0.0%
Population	5.1%	2.3%	1.9%	1.0%	0.3%	0.2%	0.0%
Adults	6.9%	3.0%	2.5%	1.6%	0.3%	0.4%	0.0%
Men	9.9%	4.1%	4.9%	2.0%	0.4%	0.2%	0.0%
Women	3.7%	1.9%	0.1%	1.1%	0.2%	0.6%	0.0%
Children	2.6%	1.4%	0.9%	0.2%	0.2%	0.0%	0.0%



2%. Among children, approximately 3% tested positive for one or more drugs with opioids at approximately 1%.

Rates by age for Kabul are presented in the Figure above. Rates in Kabul are slightly higher than the rest of urban Afghanistan for all age groups except those 45 years and older. The percent positive among those 45 years and older is approximately 8% in Kabul compared to 9% for the entire urban population.

The rates by quadrant do not differ significantly within Kabul. The northeast quadrant of Kabul has a higher rate compared to the other three quadrants at approximately 13% of households, 6% of the population, and 8% of adults. The northwest quadrant rate is lower than the other three quadrants of Kabul at approximately 8% of households, 4% of the population, and 5% of adults.

## SECOND- AND THIRD-HAND EXPOSURE TO OPIOIDS STUDY

A study was conducted between 2008 and 2011 to assess the potential consequences from women's and children's

exposure to second- and third-hand opioid smoke in the home. The term first-hand smoke refers to what is inhaled into the smoker's own lungs. Second-hand smoke is a mixture of exhaled smoke and other substances leaving the smoldering end of the substance being smoked. Second-hand smoke enters the atmosphere and can be inhaled by others. Third-hand smoke is contamination on the surfaces of objects such as eating utensils, tables, bedding, and toys that remains after the second-hand smoke has cleared. Third-hand smoke can enter the body from absorption, through contact with the residue, or ingested from hand-to-mouth transfer of the substance. Air in homes during active opioid smoking (second-hand smoke), as well as surface samples (third-hand smoke), and hair from residents of the home, were collected. The results are striking and show that children are being exposed to second- and third-hand opioid smoke, a significant public health risk.

The exposure risk was determined to be extremely high and resulted in remarkably high concentrations of opioids in infants and children. A PBPK model used the data collected from the study to simulate the possible outcome of prolonged exposure to morphine in children. The model suggests that the younger a child is during exposure, the more morphine concentrates in the brain and other vital organs. The potential long-term health effects to children require additional study, but con-

centrating morphine and possibly other opioid compounds in the brain and other tissues could be physiologically and developmentally devastating. A significant rate and number of children are also being exposed to adult cannabis use. The study shows the need for prevention programs to educate adults about the danger posed to children from smoking opioids and cannabis in the home. Treatment for children who have tested positive from exposure to adult opioid and cannabis use should be considered, especially for infants.

## CONCLUSIONS

The Afghanistan National Drug Use Survey (ANDUS) is the largest laboratory-based drug-use survey in the world body of literature. The key findings and conclusions from the survey are important for improving the design and implementation of existing and future drug prevention and treatment programs in Afghanistan.

### **#1 Drug use is prevalent throughout Afghanistan with the highest rates of drug use occurring in rural villages.**

*Drug use occurs in approximately 31% of households with 11% of the population testing positive for one or more drugs. Rural drug use is significantly higher than in the urban centers. The rural household rate is almost four times higher (39% versus 11%) and the percentage of the population who tested positive is almost three times higher (13% versus 5%).*

This is a startling and very important finding. It confirms previous interview-based surveys that found extensive drug use in Afghanistan, and now reports rates significantly higher than earlier estimates. This findings signals the need for immediate action to reduce drug use in Afghanistan, especially in the rural villages where the availability of prevention and treatment resources are currently limited.

This is a serious public health issue for children living in homes where drugs are used as well as a threat to the stability of the basic family unit. Drug use also has

long-term negative effects on the economic and social framework of Afghanistan. The consequences of drug use at the family level are clear and documented by the recent 2014 UNODC report “Impact of Drug Use on Users and their Families in Afghanistan”.<sup>1</sup> This study states that 63.6% of drug users they interviewed reported a “...deterioration of family relationships, including fights, divorce or violence...” Focus groups conducted in this study also reported that “drug use caused family violence, affected children negatively and was one of the main reason for the collapse of family relationships among drug users.”

Modern treatment programs focus on drug use not as an individual behavioral disorder but as a disease of the family. Members of the drug user’s family should be involved and educated about the dangers of drug use and the treatment of the family member. Drug use is a learned behavior, often originally learned from family members and peers then passed on from one generation to the next. This may be especially significant in Afghanistan where multi-generations and multi-families live in the same household.

Drug use is an acquired behavior that may first be seen, learned, or experienced at home. ANDUS suggests that children living in one-third of all Afghan households are seeing, learning, or experiencing adult drug use occurring in the home. This is in line with the UNODC report where it was noted that 45% of children report first using heroin at home, with 41% reporting they first obtained it from their parents. As such, home-based outreach programs and dissemination of drug prevention information in schools and community centers need to be a priority in Afghanistan to protect children and prevent the spread of drug use from one generation to the next.

<sup>1</sup> [http://www.unodc.org/documents/data-and-analysis/Studies/Impacts\\_Study\\_2014\\_web.pdf](http://www.unodc.org/documents/data-and-analysis/Studies/Impacts_Study_2014_web.pdf)

The U.S. Drug Enforcement Administration (DEA) Educational Foundation organized a traveling anti-opium street theater in 2011–2012, and more than 120,000 Afghan children and adults visited the culturally appropriate performances.<sup>2</sup> This was a significant and successful step forward in community education on the dangers of opium use and needs to continue and expand throughout Afghanistan.

**#2 Approximately 2.9 to 3.6 million Afghans could test positive for one or more drugs and 1.0 to 1.2 million of them are children. Of this total, approximately 1.9 to 2.4 million adults and 90,000 to 110,000 children could be drug users.**

*Approximately 13% of adults tested positive for one or more drugs and are assumed to be drug users. Among children, 9% tested positive for one or more drugs. Unlike adults, 91% of the children who were positive are innocent victims of adult drug use in the home.*

The 13% rate of drug use among Afghan adults is twice the adult global average rate of drug use reported by the UNODC.<sup>3</sup> The 2.9 to 3.6 million estimate of the number of Afghans who could be drug-positive is significant but not surprising because as much as 50% of the national GDP is related to opium poppy cultivation and the production of opium and heroin, with many Afghans employed in various positions/roles in the opium trade. In 2014, opium poppy cultivation rose to historically high levels, up 7% over 2013 and production of opium and heroin up 17%. In light of these statistics and Afghanistan's high non-opium-related unemployment and low literacy rates, drug use is likely to increase unless a long-term education, prevention, and treatment public service campaign is developed. This must start in the home, as noted above, be part of the curriculum in

every school in Afghanistan, and be supported by continual community education events and media campaigns. The message of a "Drug-Free Afghanistan" must be consistent and flow through every aspect of life in Afghanistan: in the homes, schools, workplaces, and in the community.

It is also important to note that drug use does not just affect the user: it affects everyone drug users come in contact with in their daily lives. It has been suggested that each drug user affects between five and 10 people around him or her: family members, friends, neighbors, co-workers, and members of the community. A conservative projection of those affected by individual drug users in Afghanistan could be almost 50% of the nation's population, and many of those so impacted are children.

Children as young as one year old tested positive for drugs. These children were not intentionally using drugs and could only have tested positive from environmental exposure or administration of the drug by an adult. Regardless of the route of administration, the two drugs most often detected are opioids and cannabis, drugs which are extremely dangerous to young children, especially infants. This is a significant threat to the health and well-being of Afghan children.

The UNODC impact survey noted that almost 50% of Afghan children self-reported they were introduced to drugs by parents. The drug-testing profile of opioid use by children parallels that of their parents. Examination of the opioid results suggest that approximately 91% of the children who tested positive are not active drug users, but innocent second- or third-hand victims of adult smoking or were given the drug by an adult.

Regardless of the route of administration, opioids in children threaten their health. Pharmacokinetic modeling suggests that the younger the child at the

<sup>2</sup> <http://www.deaeducationalfoundation.org/wp-content/uploads/2010/06/Informant-Winter-2013-Vol-7-No2.pdf>

<sup>3</sup> <http://www.unodc.org/wdr2014/>

time of exposure, the more likely morphine will build up in the brain for a number of physiological reasons. This pattern is duplicated in other tissues such as lung, kidney, liver, and skin, as well as in the saliva and blood compartments. The long-term effects are unknown and require further study, and it is probable that these children may require specialized drug education programs to prevent them from becoming drug users later in life. Only through a consistent long-term public awareness campaign can this threat to the health and well-being of Afghan children be curtailed.

**#3 Considering there may be over 2,000,000 drug users in Afghanistan, existing education, prevention, and treatment programs, especially in the rural areas, are insufficient to meet the needs of existing and new drug users.**

*There are 68 centers providing residential or inpatient treatment services and 34 providing outpatient services. These centers have the capacity to treat approximately 27,280 drug users per year on an inpatient basis. All of these centers are located in urban centers and there are only five village-based programs currently exist. These programs only provide outpatient services and for defined periods of time.<sup>1</sup>*

It is concerning that the UNODC 2009 survey reports that Afghans feel the problem of drug use is worsening and that many are unaware of available treatment programs. "Only ten percent of drug users surveyed had received a form of drug treatment, although 90% of them felt that they were in need of it."<sup>4</sup> Using ANDUS projections, this results in potentially more than 2,000,000 Afghans with limited access to drug treatment, and another generation of drug users will, based on current rates and projections, need

this treatment in the future. It is important that the capabilities and capacities of existing treatment centers be increased and that new treatment centers be built to treat drug users in Afghanistan.

The ANDUS data suggest that drug use is widespread in Afghanistan and will continue and possibly increase without a long-term national strategy of prevention, education, and treatment. Presently, drug use significantly affects the socioeconomic stability of Afghanistan and limits its future. Children are most at risk of exposure to drug use, especially opioids, with possibly more than 1,000,000 of existing Afghan children being exposed to opioids and other drugs.

With this new information in hand, it is clear that there is not enough capacity to treat those who want or are in need of drug treatment in either urban or rural settings. Expansion and improved availability and capabilities of drug treatment and prevention programs will encourage drug users not to smoke in homes, to seek treatment, and will ultimately protect the most innocent victims of drug abuse in Afghanistan: children.

In light of the poppy cultivation and processing industry being so intertwined with Afghanistan society, drug use will not decline without a major effort to support education, prevention, and treatment. Increased funding will be necessary to expand these programs and to expand capacity to treat drug users and drug-affected children.

The United States has a long history of studying the effects of drug treatment and recently reported:

According to several conservative estimates, every dollar invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed

<sup>4</sup> <http://www.unodc.org/documents/data-and-analysis/Studies/Afghan-Drug-Survey-2009-Executive-Summary-web.pdf>

costs by a ratio of 12 to 1. Major savings to the individual and to society also stem from fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths.<sup>5</sup>

Clearly, the investment in drug education, prevention, and treatment has long-term positive effects on society. However, these effects may take a generation or more to be seen in Afghanistan. The United States Department of State, the Colombo Plan, DEA Educational Foundation, other international donors,

and the United Nations have all provided culturally appropriate education, prevention, and treatment programs in Afghanistan. These programs must continue for the long-term and be funded for expansion into rural areas where the need is greatest. Drug use is a treatable chronic illness and can be controlled with appropriate treatment and follow-up programs. Funding for treatment, aftercare, and frequent testing is a long-term investment in Afghanistan that will have very positive social and economic outcomes.

<sup>5</sup> <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost>

# AFGHANISTAN NATIONAL ESTIMATES OF DRUG POSITIVES<sup>1</sup>

	Population	Adults	Men	Women	Children
<b>ANY DRUG</b>					
<b>National</b>	11.1%	12.8%	16.1%	9.5%	9.2%
Lower estimate <sup>2</sup>	2,920,000	1,920,000	1,230,000	690,000	1,000,000
Upper estimate	3,570,000	2,350,000	1,500,000	850,000	1,220,000
<b>Urban</b>	5.3%	7.5%	10.6%	4.3%	2.3%
Lower estimate	320,000	260,000	190,000	70,000	60,000
Upper estimate	390,000	320,000	230,000	90,000	70,000
<b>Rural</b>	13.0%	14.5%	17.8%	11.2%	11.3%
Lower estimate	2,600,000	1,660,000	1,040,000	620,000	940,000
Upper estimate	3,180,000	2,030,000	1,270,000	760,000	1,150,000
<b>OPIOIDS</b>					
<b>National</b>	7.4%	8.5%	10.3%	6.7%	6.0%
Lower estimate	1,940,000	1,280,000	790,000	490,000	660,000
Upper estimate	2,370,000	1,560,000	960,000	600,000	810,000
<b>Urban</b>	2.6%	3.5%	4.6%	2.3%	1.3%
Lower estimate	150,000	120,000	80,000	40,000	30,000
Upper estimate	190,000	150,000	100,000	50,000	40,000
<b>Rural</b>	8.9%	10.1%	12.1%	8.1%	7.5%
Lower estimate	1,790,000	1,160,000	710,000	450,000	630,000
Upper estimate	2,180,000	1,410,000	860,000	550,000	770,000
<b>CANNABIS</b>					
<b>National</b>	3.4%	3.8%	6.1%	1.5%	2.9%
Lower estimate	910,000	590,000	470,000	110,000	320,000
Upper estimate	1,100,000	710,000	570,000	140,000	390,000
<b>Urban</b>	1.7%	2.4%	4.7%	0.1%	0.6%
Lower estimate	110,000	90,000	80,000	< 10,000	20,000
Upper estimate	120,000	100,000	100,000	< 10,000	20,000
<b>Rural</b>	3.9%	4.2%	6.6%	2.0%	3.6%
Lower estimate	800,000	500,000	390,000	110,000	300,000
Upper estimate	980,000	610,000	470,000	140,000	370,000
<b>BENZODIAZEPINES</b>					
<b>National</b>	0.8%	1.4%	1.4%	1.4%	0.1%
Lower estimate	230,000	220,000	120,000	100,000	10,000
Upper estimate	270,000	260,000	130,000	130,000	10,000
<b>Urban</b>	1.0%	1.7%	2.0%	1.4%	0.1%
Lower estimate	60,000	60,000	40,000	20,000	< 10,000
Upper estimate	70,000	70,000	40,000	30,000	< 10,000
<b>Rural</b>	0.8%	1.3%	1.3%	1.4%	0.1%
Lower estimate	170,000	160,000	80,000	80,000	< 10,000
Upper estimate	200,000	190,000	90,000	100,000	10,000

<sup>1</sup> The estimates are based on the rate of drug positives from the urban and rural surveys. Some individuals, especially the majority of children, are not users but are positive from adult drug use in the home.

<sup>2</sup> The two population estimates are derived from the Afghanistan Central Statistics Organization (lower estimate) and CIA World Factbook (upper estimate) for 2013–2014.

# AFGHANISTAN NATIONAL ESTIMATES OF DRUG POSITIVES<sup>1</sup>

	Population	Adults	Men	Women	Children
<b>BARBITURATES</b>					
<b>National</b>	0.2%	0.2%	0.3%	0.1%	0.3%
Lower estimate <sup>2</sup>	50,000	20,000	20,000	< 10,000	30,000
Upper estimate	70,000	40,000	30,000	< 10,000	40,000
<b>Urban</b>	0.3%	0.4%	0.7%	0.2%	0.2%
Lower estimate	10,000	10,000	10,000	< 10,000	< 10,000
Upper estimate	20,000	20,000	20,000	< 10,000	< 10,000
<b>Rural</b>	0.2%	0.1%	0.2%	0.1%	0.3%
Lower estimate	40,000	10,000	10,000	< 10,000	30,000
Upper estimate	50,000	20,000	10,000	< 10,000	30,000
<b>ALCOHOL</b>					
<b>National</b>	0.1%	0.2%	0.1%	0.3%	0.1%
Lower estimate	30,000	30,000	< 10,000	30,000	< 10,000
Upper estimate	40,000	40,000	10,000	30,000	< 10,000
<b>Urban</b>	0.3%	0.4%	0.3%	0.5%	0.1%
Lower estimate	10,000	10,000	< 10,000	< 10,000	< 10,000
Upper estimate	20,000	20,000	< 10,000	10,000	< 10,000
<b>Rural</b>	0.1%	0.1%	0.0%	0.3%	< 0.1%
Lower estimate	20,000	20,000	< 10,000	20,000	< 10,000
Upper estimate	20,000	20,000	< 10,000	20,000	< 10,000
<b>AMPHETAMINE-TYPE STIMULANTS</b>					
<b>National</b>	0.3%	0.5%	0.9%	0.1%	0.1%
Lower estimate	80,000	70,000	60,000	< 10,000	10,000
Upper estimate	100,000	90,000	80,000	< 10,000	10,000
<b>Urban</b>	< 0.1%	< 0.1%	< 0.1%	0.0%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
<b>Rural</b>	0.4%	0.6%	1.1%	0.1%	0.1%
Lower estimate	80,000	70,000	60,000	< 10,000	< 10,000
Upper estimate	100,000	90,000	80,000	< 10,000	10,000
<b>OTHER DRUG CLASSES</b>					
<b>National</b>	< 0.1%	0.1%	0.1%	< 0.1%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
<b>Urban</b>	0.0%	0.0%	0.0%	0.0%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
<b>Rural</b>	< 0.1%	0.1%	0.1%	0.1%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000

<sup>1</sup> The estimates are based on the rate of drug positives from the urban and rural surveys. Some individuals, especially the majority of children, are not users but are positive from adult drug use in the home.

<sup>2</sup> The two population estimates are derived from the Afghanistan Central Statistics Organization (lower estimate) and CIA World Factbook (upper estimate) for 2013–2014.

# AFGHANISTAN NATIONAL ESTIMATES OF DRUG USE<sup>1</sup>

	Population	Adults	Men	Women	Children
<b>ANY DRUG</b>					
<b>National</b>	7.3%	12.8%	16.1%	9.5%	0.8%
Lower estimate <sup>2</sup>	2,010,000	1,920,000	1,230,000	690,000	90,000
Upper estimate	2,460,000	2,350,000	1,500,000	850,000	110,000
<b>Urban</b>	4.4%	7.5%	10.6%	4.3%	0.2%
Lower estimate	270,000	260,000	190,000	70,000	< 10,000
Upper estimate	330,000	320,000	230,000	90,000	< 10,000
<b>Rural</b>	8.2%	14.5%	17.8%	11.2%	1.0%
Lower estimate	1,740,000	1,660,000	1,040,000	620,000	80,000
Upper estimate	2,130,000	2,030,000	1,270,000	760,000	100,000
<b>OPIOIDS</b>					
<b>National</b>	4.9%	8.5%	10.3%	6.7%	0.6%
Lower estimate	1,340,000	1,280,000	790,000	490,000	60,000
Upper estimate	1,630,000	1,560,000	960,000	600,000	70,000
<b>Urban</b>	2.0%	3.5%	4.6%	2.3%	0.1%
Lower estimate	120,000	120,000	80,000	40,000	< 10,000
Upper estimate	150,000	150,000	100,000	50,000	< 10,000
<b>Rural</b>	5.7%	10.1%	12.1%	8.1%	0.7%
Lower estimate	1,220,000	1,160,000	710,000	450,000	60,000
Upper estimate	1,480,000	1,410,000	860,000	550,000	70,000
<b>CANNABIS</b>					
<b>National</b>	2.2%	3.8%	6.1%	1.5%	0.2%
Lower estimate	620,000	590,000	470,000	110,000	30,000
Upper estimate	740,000	710,000	570,000	140,000	30,000
<b>Urban</b>	1.4%	2.4%	4.7%	0.1%	< 0.1%
Lower estimate	90,000	90,000	80,000	< 10,000	< 10,000
Upper estimate	100,000	100,000	100,000	< 10,000	< 10,000
<b>Rural</b>	2.4%	4.2%	6.6%	2.0%	0.3%
Lower estimate	530,000	500,000	390,000	110,000	30,000
Upper estimate	640,000	610,000	470,000	140,000	30,000
<b>BENZODIAZEPINES</b>					
<b>National</b>	0.8%	1.4%	1.4%	1.4%	< 0.1%
Lower estimate	220,000	220,000	120,000	100,000	< 10,000
Upper estimate	260,000	260,000	130,000	130,000	< 10,000
<b>Urban</b>	1.0%	1.7%	2.0%	1.4%	< 0.1%
Lower estimate	60,000	60,000	40,000	20,000	< 10,000
Upper estimate	70,000	70,000	40,000	30,000	< 10,000
<b>Rural</b>	0.7%	1.3%	1.3%	1.4%	< 0.1%
Lower estimate	160,000	160,000	80,000	80,000	< 10,000
Upper estimate	190,000	190,000	90,000	100,000	< 10,000

<sup>1</sup> Adults, Men, and Women user estimates are the same as drug positives. Children estimates are 9% of drug positives based on the criteria outlined in the report.

<sup>2</sup> The two population estimates are derived from the Afghanistan Central Statistics Organization (lower estimate) and CIA World Factbook (upper estimate) for 2013–2014.

# AFGHANISTAN NATIONAL ESTIMATES OF DRUG USE<sup>1</sup>

	Population	Adults	Men	Women	Children
<b>BARBITURATES</b>					
<b>National</b>	0.1%	0.2%	0.3%	0.1%	< 0.1%
Lower estimate <sup>2</sup>	20,000	20,000	20,000	< 10,000	< 10,000
Upper estimate	40,000	40,000	30,000	< 10,000	< 10,000
<b>Urban</b>	0.2%	0.4%	0.7%	0.2%	< 0.1%
Lower estimate	10,000	10,000	10,000	< 10,000	< 10,000
Upper estimate	20,000	20,000	20,000	< 10,000	< 10,000
<b>Rural</b>	0.1%	0.1%	0.2%	0.1%	< 0.1%
Lower estimate	10,000	10,000	10,000	< 10,000	< 10,000
Upper estimate	20,000	20,000	10,000	< 10,000	< 10,000
<b>ALCOHOL</b>					
<b>National</b>	0.1%	0.2%	0.1%	0.3%	< 0.1%
Lower estimate	30,000	30,000	< 10,000	30,000	< 10,000
Upper estimate	40,000	40,000	10,000	30,000	< 10,000
<b>Urban</b>	0.2%	0.4%	0.3%	0.5%	< 0.1%
Lower estimate	10,000	10,000	< 10,000	< 10,000	< 10,000
Upper estimate	20,000	20,000	< 10,000	10,000	< 10,000
<b>Rural</b>	0.1%	0.1%	0.0%	0.3%	< 0.1%
Lower estimate	20,000	20,000	< 10,000	20,000	< 10,000
Upper estimate	20,000	20,000	< 10,000	20,000	< 10,000
<b>AMPHETAMINE-TYPE STIMULANTS</b>					
<b>National</b>	0.3%	0.5%	0.9%	0.1%	< 0.1%
Lower estimate	70,000	70,000	60,000	< 10,000	< 10,000
Upper estimate	90,000	90,000	80,000	< 10,000	< 10,000
<b>Urban</b>	< 0.1%	< 0.1%	< 0.1%	0.0%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
<b>Rural</b>	0.3%	0.6%	1.1%	0.1%	< 0.1%
Lower estimate	70,000	70,000	60,000	< 10,000	< 10,000
Upper estimate	90,000	90,000	80,000	< 10,000	< 10,000
<b>OTHER DRUG CLASSES</b>					
<b>National</b>	< 0.1%	< 0.1%	< 0.1%	< 0.1%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
<b>Urban</b>	0.0%	0.0%	0.0%	0.0%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
<b>Rural</b>	< 0.1%	0.1%	0.1%	0.1%	0.0%
Lower estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000
Upper estimate	< 10,000	< 10,000	< 10,000	< 10,000	< 10,000

<sup>1</sup> Adults, Men, and Women user estimates are the same as drug positives. Children estimates are 9% of drug positives based on the criteria outlined in the report.

<sup>2</sup> The two population estimates are derived from the Afghanistan Central Statistics Organization (lower estimate) and CIA World Factbook (upper estimate) for 2013–2014.





## COLOMBO PLAN

No.31, Wijerama Mawatha, Colombo 7, | P.O.Box: 596, Sri Lanka

T: +94 11 2684188, +94 11 2694183-5 | F: +94 11 2684386

[www.colombo-plan.org](http://www.colombo-plan.org)